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Surgeons —

SYPHILITIC ERUPTIONS

OF THE SKIN;

(2)

OR,

The Syphilo-Dermata.

Containing a Contrasted Parallel of the Stages and Symptoms of Acquired and Inherited Syphilis.

BY

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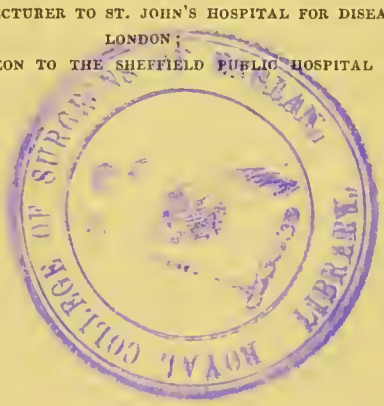

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At the desire of many professional friends I have been induced to publish this short work on the Syphilitic Eruptions of the Skin, mainly the matter of two Lectures I delivered to the Members of the Willan Society of London this year, and in the course of usual annual Lectures at the close of last year at St. John's Hospital for Skin Diseases. So large a proportion of such cases occurring both in hospital and in private practice, I deemed the subject of sufficient importance to lecture upon, and I hope to give it much attention in the chapter devoted to Syphilitic Eruptions, in the work upon the Skin I am now engaged upon. I venture a hope that the work may be of some interest to practitioners, and of use to students in dermatology.

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SYPHILITIC ERUPTIONS,

OR,

The Syphilo-Dermata.

CLASSIFICATION.

CLASS.	VARIETY.
1. Bulous Syphiloderm	Rupia. Pemphigus.
2. Erythematous ditto	Roseola. Erythema.
3. Papular ditto	Lichen.
4. Pustular ditto	Folieulitis. Acne. Ecthyma.
5. Squamous ditto..	Psoriasis, Psoriasis Palmaris and Plantaris.
6. Tubercular ditto	Tubercular Syphilis.
7. Ulcerative ditto	Syphilitic Ulceration.
8. Vesicular ditto	Herpes. Eczema. Varioliform.
9. Changes in Hair and Nails ..	Alopecia. Onychia.

Introduction—Definition of Syphilis—Acquired Syphilis—Syphilitic Fever—False or Pseudo-Syphilis—Soft Chancre—Comparison—Period of Incubation of true Syphilis—Period of Local Eruptions—Period of Secondary Eruptions—Characters—Symmetry—Form—Scales—Crusts—Polymorphism—Classification.

Affections of the Mucous Membrane—Superficial Ulceration—Mucous Patches—Vegetations—Icterus—Syphilitic Iritis, comparison with Rheumatic Iritis—Tertiary affections of the Skin—Period of gummy Affections of the Skin—Deep-seated Pustular Syphiloderm—Circumscribed lesions of the Skin—Pathology—Diagnosis—Treatment—Dict—General Hygiène—Complications—Lupus Gout—Rheumatism—Hereditary or Congenital Syphilitic Eruptions.

Introduction.—If I were to attempt to discuss the origin of syphilis, and to describe the primary disease, from which spring all the various syphilitic diseases of the skin, I should certainly occupy much more space than I think it expedient to devote at the present time. I

propose simply to consider the secondary and tertiary eruptions of the skin and mucous membrane, *i.e.*, those various eruptions of the skin, mucous membrane, affections of the hair and nails that occur to our notice, brought about by the entrance into the system of the syphilitic poison.

Definition.—Syphilis is a specific disease, characterised by a slow, progressive development. It may be either *acquired* or *hereditary*.

Acquired, when it has been transmitted by actual contact or by inoculation.

Hereditary, when it can be traced back to either parent.

It occurs in separate and distinct forms. The first has its primary manifestation at the site of contamination. The second manifests itself by various symptoms which show themselves in different parts of the body. The third affects the bones and deep tissues.

Acquired Syphilis.—The dermatologist becomes interested in the subject of syphilis as soon as it begins to operate upon the system. Unlike the poison of eruptive fevers, that of syphilis is transmitted only by contact, by contagion, or inoculation alone, sometimes through the blood, sometimes through the secretions—sometimes from secretion of an infecting sore, most often in the latter mode.

According to Mons. Ricord, syphilis may be divided into three periods.

1st. *Primary lesion*, chancre, the immediate result of contagion.

2nd. *Secondary lesions*, constitutional poisoning resulting from infection.

3rd. *Tertiary lesions*, which as a rule do not show themselves for six months.

Virchow arranges it in two groups—1st, the negative characters, cachexia, with its various lesions; 2nd, the active or irritative phenomena, with its various inflammations and new growths.

Guided by these two great authorities on the subject, we may safely recognize the following stages:—

1st. Period of incubation.
2nd. Period of local eruption or primary lesion.
3rd. Period of general eruption, or secondary affections.
4th. Period of gummy affections, or tertiary manifestations.

The operation of the disease in its first instance gives rise to some amount of fever, syphilitic fever, and at this time the skin becomes first affected, accompanied with neuralgic pain and sore throat.

Syphilitic Fever generally commences about the sixth to the ninth week after the evidence of the primary disease. There is a rise in temperature of the body to 101° and 102°, but here much difference manifests itself, whereas true exanthematous fevers are regular in progress, they are not prone to recur, syphilitic fever is very irregular in its habit, uncertain in duration, and liable to relapses, sometimes months, after its first onset. It is accompanied generally by a roseolous rash, and there is a general feeling of depression, prostration, neuralgia, foul tongue indented by the teeth, the skin loses its smooth healthy character, becomes hard and dry and of a mottled, dirty appearance. The fauces become congested, and the tonsils and soft palate swollen and inflamed.

There is also sleeplessness and nocturnal pains in the joints and sometimes night sweats. Indeed the patients complain of feeling bodily ill. After this fever eruptions of various kinds follow, which seem to feel their way gradually, in the skin. Firstly, as *erythema*, then an

additional growth is added to the erythema, a papule is formed, an eminence on the skin, ranging in size from a line to an inch. These eruptions arrange themselves into the erythematous, papulous, and ulcerous forms.

These symptoms are all much varied in intensity by the early treatment of mercury.

Before I refer to these various forms and their particular varieties, I propose to say something about "*Pseudo-Syphilis, or false syphilis.*"

False syphilis, simple chancre or soft chancre, non-infecting or non-suppurating chancre, is well known and has often been described. Any part of the body may become the site of the soft chancre; but the genital organs, as they are most frequently exposed to the contact of the virulent matter, are the parts most frequently affected. In males, the genital organs, the glands, and prepuce; in females, the labia majora and minora. Unlike the indurated chancre, it becomes developed in a short time, in two or three days. The base of a soft chancre generally presents the same soft character as the surrounding skin, but never that elastic, indurated character of base, like the true Hunterian chancre, and it is more multiple in its onset. Its course is continuous and progressive, and there is a tendency to invade and destroy the surrounding tissue. After about four weeks the ulcers cease to spread, and upon a clean surface a healthy pus begins to form. Then cicatrization begins to form from the circumference to the centre, leaving no induration but a depressed white cicatrix. Complications more frequently arise with soft chancre than hard, viz., phymosis, paraphymosis—inflammation, phagedæna, and gangrene. From these facts we may draw the following conclusions

1st. That a single soft chancre is not followed by constitutional syphilis.

2nd. Nor does it transmit induration or true syphilis.

3rd. That under certain conditions soft chancre may proceed from an indurated chancre.

By the *Period of Incubation of True Syphlis*, we infer that period of time which elapses between the commencement of the absorption of the syphilitic poison and the appearance of the first local manifestation. This period of time has now been determined, and it is almost possible to fix the exact period of incubation. Thus it appears, that from the time of actual inoculation to the first symptom (indicative of general infection), the disease shows itself from the eighteenth to the thirty-fifth day, giving a mean of twenty-seven days. Thus, *Mons. Vidal*, in the "*Annales des Maladies de la Peau*," 50–1, p. 115, dating the commencement from Ecthymatous pustules thirty-five days, the Primary lesion, or indurated chancre, followed by secondary symptoms in 128 days, Roseola and mucous patches.

The Period of Local Eruptions is that which includes the interval of time which takes place from the date of the reaction of the organism at the site of contact begins to appear, to the time which the first manifestations follow, *i.e.*, 1st. The local changes at primary point of lesion; 2nd. The changes in the lymphatic system, enlarged glands.

The name Hunterian or indurated chancre has long been recognised as the first manifestation of true syphilis, which shows itself—1st. As a dry papule. 2nd. As a chancrous erosion. 3rd. As an indurated chancre. This lesion is so well known, that I need not enter here on its accurate anatomical description, but it is generally known by a coppery-red spot, slightly raised papule, afterwards desquamating, and becoming covered with crusts, and finally eroded or ulcerated on its surface. Its most common situation is on the outer surface of the penis or on the corona of the glans penis.

The duration of this lesion varies from one to two months—generally one—and terminates by resolution and cicatrization, but not by permanent cicatrices. The induration, however, lasts some time. In females the chancre is situated generally on the labia majora, and is distinctly indurated; sometimes, however, it is found on the neck of the uterus.* They may have also extra-genital chancres on the limbs, anus, and mouth, Gangrene and Phagedæna are the only complications generally to be met with in primary syphilis.

The Period of Secondary Eruptions.—Syphilis appears now, not as a local lesion, but in a number of morbid forms. After the specific fever, and a variable period of from thirty to fifty, and sometimes seventy days, a new symptom shows itself in the superficial parts of the skin and mucous membranes—the exanthematous syphiloderm, and various other eruptions, as I have mentioned before, the general characters of which are:—

1st. Generally symmetrical.

2nd. Their form crescentic or circular.

3rd. Their scales thin, very fine, ashy-grey in colour, and fewer than in the non-specific eruptions.

4th. Their crusts thick, firmly adherent, greenish or black. When these crusts are removed, an ashy-grey ulceration is exposed, defined by sharply cut edges, and the horseshoe shape is generally very characteristic.

5th. Their colour is generally described as copper-like, or a reddish-brown. A dull red at first, becoming deeper and browner as it progresses, the stain remaining sometimes long after the lesions. It is especially well marked as areola in the pustular and tubercular varieties of eruption, and at the edges of ulcers.

POLYMORPHISM is a very common feature in connection with syphilitic eruptions. It is a common thing to see

* Ricord, Bernatz.

papules, vesieles, pustules, and tubereules eo-exist in the same individual case, and one form of eruption gradually coalesce into another.

We are accustomed to separate the eruptions consequent on the primary disease, into secondary and tertiary, but there is really no distinct time of juncture.

The secondary eruptions are those which take plaee in the early stages of the disease, and are more superficial—the tertiary are those whieh occur later, and are eonfined to the subcutaneous tissue and deeper parts, the museles and bones.

In chronological order, the first eruption we meet with is the *Bulous syphiloderm*, of which class we have rupia and pemphigus as its varieties.

Rupia Syphilitica we may see commence as small flat bullæ, containing a serous fluid, or as a small hard subcutaneous tubercle, readily felt with the finger, and freely movable. This may remain dormant for some weeks, or it may come to the surface, when much pain is experienced, and uleeration quickly follows. The secretion is at first thin and offensive, and, should the erust be allowed to form, it beeomes very thick and prominent, beneath which is to be found more or less unhealthy ulceration. Rupia may be seated on any part of the body—the face, head, limbs, or trunk—and, besides the characters mentioned above, one or two points may be notieed in connection with thesc sores. The discharge from them is commonly tinged with blood. The edges arc eleanly cut and circular as if scooped out with a seoop. Often rupia is associated with a cracked and fissured tongue, or with a specific nodule in its substanee, only to be felt by eompressing the organ betweeu the thumb and finger. The pain is usually felt towards morning, while the patient is in bed. The prominent crusts are formed in the following

manner—as the area of the ulcer increases, so the crusts increase by successive layers of dried secretion, gradually accumulating from above downwards; and, if the face is the part attacked, great disfigurement results, as at the time the affected part not only presents a number of raised scabs, painful and difficult to remove, but conceals under them a quantity of nasty yellow pus, the surrounding skin is stained and scarred, and the cicatrices remain after recovery. If they occur on the scalp, the hair does not resume its natural growth, sometimes it does not grow at all.

Rupia is almost always a sequence of syphilis, and is met with amongst those who are debilitated by excesses, or have other complications to reduce the health of the system, and sometimes this eruption is delayed for years after the primary symptoms of syphilis. This disease generally yields rapidly to treatment, and recovery, with the exception of the cicatrix, is generally permanent, but like many of the specific lesions of the skin, is liable to relapse. The constitutional treatment is most important in rupia. Iodide of potassium, in ten to twenty grains, with or without moderate doses of perchloride of mercury, the sores washed with black wash, or if deeply excavated, touched with caustic, and a liberal diet should be allowed the patient.

The other variety of the bulous syphiloderm is *Pemphigus* or *Pomphlox*. As a syphilitic disease it is rare, and has been questioned, but on insufficient authority. It commences as hard shining tubercles, which rapidly enlarge, and of a dull reddish-brown tint. They chiefly occur on the face and upper extremities. They vary in size from a pea to that of a small orange. These tumours gradually fill with a sero-purulent fluid, and present all the characters of acute pemphigus. But it is in the early and inherited

form of the disease, it is to be most often met with, and is generally accompanied by all the concomitant symptoms of congenital syphilis, viz., dirty hue of the skin, snuffles, wasting, and mucous tubercles. It is observed on the hands and feet and possesses a tendency to ulcerate deeply, and it is noticeable at the end of the first fortnight of life. Here we have the link between rupia and pemphigus.

We next come to the *Erythematous* or early manifestation of syphilis, as evinced by the varieties of roseola and erythema.

ERYTHEMA is characterized by spots or maculæ not raised above the surface, of a dull rose colour, which disappear on pressure; *roseola*, sometimes by patches of a bright red or dark red colour, slightly raised, not altered by pressure. Hence the two varieties, macula erythema or roseola, and papular erythema. It commences about the sixth or ninth week after the onset of the primary disease, sometimes general in its eruption, sometimes limited to a portion of the body. It is generally preceded by some pyrexia, prostration, and inflammation of the fauces.

The eruption commences upon the sides, the chest, shoulders, inner surfaces of the extremities, as small spots of a pale rose colour, from the size of a pea to a shilling, which may appear very suddenly, even in a single night, over all the sites above-mentioned. The face may also become the situation of the eruption. The eruption is sometimes modified according to the region in which it is observed. Thus the dorsal surface may be the site of rose-coloured spots, and palmar and plantar surfaces with spots of a papular character.

When this rash fades, generally in the course of a few days, the epidermis desquamates and the characteristic coppery red stains are left behind. These are the so-called

maculæ syphiliticæ. It seems to me that the blood corpuscles undergo decomposition, and that this colouring matter becomes diffused in an altered form through the system, but this discoloration is not always to be noticed in early syphiloderms, it is better marked in the later stages of the disease, when the syphilitic cachexia is more confirmed.

An evidence also of the altered condition of the nutrition of the skin is the formation of horny epidermis and its consequent exfoliation.

In specific erythema we have simple hyperæmia cutis, in patches, uniform in colour, or hyperæmia in small spots without elevation; hyperæmic slightly raised patches like erythema papulosum, spreading in well-defined rings, and a circular area in which the skin becomes natural in state. It runs a slow course; it is liable to relapses, influenced by excessive fatigue or excesses of spirituous drinks.

Regarded as a cutaneous eruption, erythematous syphilis is a benignant affection, and does not cause destruction of the skin. As a prognostic point, roseola is less unfavourable than most of the syphilitic eruptions. This opinion, I believe, is held by many observers—that there is absence of serious relapses following erythematous syphilides.

The *Papular syphiloderm* is known by protuberances of greater or less size, disseminated, dry and round, occurring generally upon the trunk, especially the abdomen, sides and back, and it may also be seen upon the limbs and forehead. The papules seldom exceed in size a small lentil seed, their colour is very variable, at first they appear rose-pink, and then a dull red, which does not disappear on pressure. There are generally two varieties, *acute* and *chronic*. The eruption attains its maturity in about two days, and the papules are collected together in groups.

That of the more chronic form manifests papules, large, flat, and numerous, and of a deeper red, without distinct areola. The papules are successive in their appearance, but after a longer or shorter time they gradually decline and become covered with a scab, which breaks and leaves a ring. Papular syphiloderm presents several varieties, lenticula papules and flat papules. It frequently is seen upon infants.

The characteristic of the papules seen upon the soles of the feet and palms of the hands, is, that they are covered with scales resembling psoriasis.

The diagnosis of papular syphiloderm or *syphilitic lichen* is easily made, as a rule. The general sites of the eruption, its colour, its tendency to form tubercles, its absence of pruritus, and its after accompanying symptoms of mucous tubercles, nodes, sore throat, and roseola, are sufficient evidence.

Under the name of *pustular syphiloderm* is known a disseminated eruption, characterized by a collection of pus, leaving a slight cicatrix behind.

The primary forms of this class are *Syphilitic foliculitis* —syphilitic acne, and syphilitic ecthyma. The secondary form is that which is tubercular in character and ulcerates. The eruption in point of frequency comes immediately after the erythematous and papular syphiloderms. The pustular eruption may extend to the whole surface of the skin, but usually it commences upon the scalp or face, whence it spreads to the trunk or limbs. The most superficial parts of the skin about the hair are the sites attacked. The pustules are about the size of a small lentil, composed of a red base, surmounted by a vesicle filled with serum or pus. *Syphilitic foliculitis.* In this eruption the disease, as may be imagined, attacks the follicle above the opening of the sebaceous glands, and is

seen upon the sealp and face most frequently. It occurs in the early stages of syphilis generally, and is very indolent in its course. *Syphilitic acne* is a common eruption, and is seen usually upon the face, especially upon the sides of the face, or the shoulders; unlike simple acne, it leaves the checks free from eruption, and it is not limited to the face alone, but occurs in patches on different parts of the trunk. The spots are about the size of a lentil seed or pea, they have a hard base, and are often like small-pox pustules in appearance, they also leave pits behind them, and dark-coloured stains.

Acne Rosacea is sometimes also due to syphilis. It is noticed as a crimson flush, which forms a continuous patch extending over the nose, as well as the adjacent surface of the face. It lacks the smarting symptom which is usually associated with simple acne rosacea, and the oily secretion, which is the usual accompaniment of true acne.

Syphilitic Ecthyma is usually seen upon the trunk, the lower extremities especially—occasionally the head. The pustules are large, scattered, with coppery base, and are covered with brown or yellowish-brown crusts (leading us to call it impetiginous at times), covering ulcers with indurated and dark edges, which heal with the characteristic cicatrices and stains. The prognosis of pustular syphiloderm is not so favourable as the preceding class, as it is more liable to frequent relapses, and the disease occupies a greater extent of surface. I have seen it occupy sometimes patches of six or seven inches in circumference. The purulent exudation also is more severe.

Diagnosis.—When it is preceded by general symptoms, the phlyzacious pustular syphiloderm might be mistaken for an attack of small-pox, but the difference of course lies in its antecedent history. Common acne and scabies may also in the same way be mistaken for it. The relation of

rupia, pemphigus, eethyma of syphilitie origin are of very elose assoeiation, but they eaeh have their several distinet eharaeteristies.

We now eome to the *Squamous syphiloderm*, with its varieties of *Psoriasis*, and *Psoriasis palmaris et plantaris*, the latter almost diagnostie of syphilis in themselves. The existence of squamous syphiloderm was eontested by many authors until reeently, but now it is generally reeognised. It presents several varieties. Psoriasis guttata, is seen as small round isolated spots, from the size of a pea to that of a shilling, eovered with small fine white seales, not firmly attaehed, elevated, or papular. There is a disposition for the eruption to invariably assume a eireular direetion. These spots are seen generally seattered over the trunk, and upper extremities on the *flexor* surfaees, and on the faee. The elbows and knees usually eseape, whereas in simple psoriasis, they are usually affeeted.

The eireinate syphilitie psoriasis is remarkable for its eireular eharaeter, and is most frequently situated upon the face. It eommences as reddish-brown spots, prominent, forming eireles or horseshoe shapes, the eentral area generally being healthy, upon these patehes are found fine non-adherent seales, and they repose upon a eoppery base.

Syphilitie palmar and plantar psoriasis, as these names signify, oeeupy the palms of the hands and the soles of the feet. They are known by slightly prominent, round spots of eoppery eolour, eovered with hard grey seales, whieh in some instanees, take the form of craeked patehes, and give rise to fissures, which are at times painful. These are the several symptoms whieh are perfeetly diagnostie of syphilitie psoriasis.

1st. That when found on the palms of the hands and soles of the feet, it may safely be diagnosed as syphilitie,

but care must be taken, as simple psoriasis undoubtedly does occur on the palms of the hands, so also, does dry eczema, and I have seen them both in spite of what has been said to the contrary.

2nd. The disease is not found on the elbows and knees, as is the case in simple psoriasis.

3rd. It generally assumes a circular or crescentic shape, isolated and not confluent.

4th. The scales are thin, grey, small, non-adherent, and recline upon a coppery base.

5th. There are the general co-existences of syphilis with its stains.

The scales of true psoriasis are brighter, more numerous, the skin bleeds, if forcibly removed, they are usually situated on a bright hyperæmic base, and there is the invariable itching, not felt in the specific variety.

The simplest manifestations of *Tubercular syphilis* are seen as a few scattered tubercles, which vary in size a good deal, from a pea to a nut, always indolent in character, and occur about the face, nose, forehead, indeed, in any part of the body, sometimes closely packed together as to make one thickened mass, presenting a dark coppery hue, they are flat and hard. Sometimes they ulcerate, then they become covered with black adherent scales and crusts, but the general characteristic is a dense firm fleshy eminence of a dark coppery hue, either disseminated or arranged in the form of rings, or grouped together in patches.

That of the annular form is made up of tubercles of granulation tissue, extending by gradual enlargement from the primary ring, new tubercles forming with new infiltration, and new tissue. Then further changes may take place, viz.: suppuration and ulceration, *i.e.*, some of the tubercles in debilitated constitutions break up and form unhealthy pus, which drys up into crusts, and here we

have the connecting link between tubercular and ulcerative syphilis.

With regard to the *Diagnosis* of tubercular syphilis, the eruption itself is diagnostic, there is no eruption like it. The nearest approach is true leprosy, and this is so rare, in this country we may eliminate it in our diagnosis.

There is no tubercle like the coppery, firm, flat fleshy-like tubercle of syphilis, unmistakable when once seen, and the history of the case, with its accompaniments of gumma, mucous tubercles, ulcerative tongue, all lead to a certain diagnosis.

The *Ulcerative syphiloderm.* In ulcerating syphilis of the skin the ulceration may be deep and is called the ulcerating form ; in the other superficial, the serpignous form. This state of ulceration is remarkable for its production of abundant vicious, puriform, exudation with thick crusts. In the first form the ulcer is perforating or deeply ulcerating. In it the tubercles are large, pus of coppery hue and areola, having a tendency to ulcerate deeply, attended with pain. They commence somewhat in the following manner: First, with hyperæmia, then thickening, upon the tubercle ; the cuticle becomes raised into a vesicle of greater or less extent, filled with puriform matter. This puriform matter dries up into a crust, while fresh matter is formed under it, and thus, by a centrifugal process, the crusting and ulceration progresses.

These ashy-coloured and foul ulcerations may become confluent and excavate the tissues more deeply, so that large areas may be destroyed, viz., the lips, or the alæ of the nose, the face being its commonest situation.

This disease much resembles lupus in its character, only that the ulceration of lupus is much slower in its progress, and is not so amenable to treatment. The superficial or creeping ulceration progresses, in circles, the surfaces

become covered with crusts, sometimes the entire leg or arm may be encircled by this creeping form of ulceration, and it leaves behind it livid cicatrices which take considerable time to repair.

There is also a form of ulceration in connection with lupus which I cannot find described, but which I have seen. It is situated in the face, and it has all the reparative characters of lupus, with cicatrices peculiar to lupus, but accompanied with all the symptoms of syphilis. The tubercular tissue is more vascular and glutinous-looking than that of lupus. It may be designated as *syphilitic lupus.*

We now come to the *Vesicular syphiloderm*, with its varieties of herpes, eczema, and varioliform syphiloderm. The designation vesicular has been questioned by authors, notably by the late Sir Erasmus Wilson. The disease no doubt is very rare. I have seen but two or three cases. I have now a gentleman under my care, who had this variety very characteristically marked on the face and trunk as single isolated vesicles, much like the chicken-pox. This eruption is characterized, as its name indicates, by the presence of small serous vesicles, distributed over all the surface of the skin, and assumes the form of herpes in most cases, but it may be varioliform or eczematous. The herpetic eruption presents vesicles arranged in irregular groups, like the variety, herpes phlyctenoides, or in rounded groups like herpes circinatus. This eruption generally shows itself at an early date, about six months after the onset of the disease, and is accompanied by all the symptoms of the primary disease. The vesicles are more indolent, and have not that attendant heat and itching that ordinary herpes has, and the patches grow by the centrifugal development, and a coppery stain is invariably left when resolution takes place. This form of specific

herpes is found upon the face, limbs, trunk, and penis; it is most common in the latter situation. It may also occur in the usual situation of herpes zoster—round the loins. The eruption lasts longer than the ordinary forms of herpes, and it is followed by a squamous stage, which lasts sometimes a month. The vesicles terminate in resolution, sometimes slightly ulcerating, in which cases they leave behind small cicatrices, which gradually disappear. These forms of herpes seem to me to be due to irritation of the nerve trunks in a special syphilitic diathesis.

Syphilitic Eczema is very rare, it is more often seen as syphilitic eczema-impetiginodes, and is usually seen upon the face. Its characters are much the same as those of ordinary eczema, that is to say, vesicles arranged in irregular groups, sometimes transparent, sometimes disseminated, occupying the hair follicles of the skin, sometimes opaque and becoming covered with yellowish crusts, hence its name, eczema impetiginodes syphilitica.

In the variety of varioliform syphiloderm, the vesicles are disseminated, about the size of lentil seeds or peas, which are sometimes globular, pointed, or depressed in the centre, filled with sero-purulent fluid, hence its greater likeness to varioloid, than chicken-pox. Each vesicle is surrounded by the usual coppery areola, and leaves behind the coloured stain.

Diagnosis. The slowness of the course, and the usual concomitant symptoms of these eruptions, leave but little doubt as to the diagnosis, but the distinctive feature, is the absence from itching and the coppery colour.

Prognosis. These eruptions, with the exception of herpes preputialis, are not liable to recur, and they are always the first symptom, consequent on the primary lesion six months after contagion.

We now come to *specific alopecia*, which is the partial or

total falling off of the hair of the head and other parts of the body, and may be regarded as one of the most important evidences of constitutional syphilis. It is a common affection, and it occurs in the early stages of the disease, during the time of specific pyrexia, or it may occur as well defined localized patches, the result of some ulcerative lesion of the scalp, accompanied by periostitis. The first modification of the hair is unusual dryness, it loses its brilliancy, becomes brittle, woolly, and sometimes change of colour takes place by reason of deficiency of pigment, *i.e.*, black hair, may turn grey.

The hair comes out easily when brushed, and in patches of greater or less extent, and most commonly the falling off occurs at the temporal region, but it may strip the whole hairy surfaces of the body. The evolution of alopecia is slow, extending, even under treatment, to several months, but complete recovery as a rule takes place under treatment, the hair resuming all its natural qualities.

I look upon this pathogenic condition as one of an anæmia of the hairy scalp produced by syphilitic disease.

This condition of alopecia is not a symptom of secondary syphilis only. It occurs after typhoid, scarlet, and puerperal fevers, therefore it is important to recognize the specific variety. The ordinary baldness that affects the upper and middle parts of the skull is rarely specific.

The change that takes place in *Syphilitic onychia*, is a consequence of changes taking place in, or a modification of the matrix of the nails, which is the secreting organ of the horny substance. It may attack the substance of the nail itself, or it may attack several nails at the same time, it is a secondary symptom in the adult, and ends with exfoliation of the nails.

The symptoms are pain, redness, and swelling, round

the base of the nail, followed by suppuration and ulceration of the matrix, and loss of the nail; in addition to this the subungual groove is invaded by mucous patches, from which oozes a peculiar whitish or brownish matter.*

It is also described as follows:—A semilunar furrow is seen extending across the nail near the root, the outermost layer is destroyed almost over its entire lanula, a ragged border overhanging that part, is presented by the distal portion, and as the nail grows, the diseased portion is pushed further and further on. The nails seem brittle and fissured in texture, and split and broken at the ends, and dotted over with small specks or indentations. We may also have a spontaneous ulceration of the secreting organ of the nails of either the hands or feet, a distressing and painful affection round the root and under the extremity of the nail. It presents a moist fungating appearance, easily bleeds, and a fœtid, ichorous discharge issues from it. The extremity of the nail becomes detached, which detachment extends insensibly to its base, and is followed by ulceration of its new surface, the nail becoming reduced to a few horny shreds.

These various lesions of the nails, form part of the secondary symptoms, and co-exist generally with secondary symptoms. It is rarely that the secondary syphilis exists long in a system, without the nails becoming affected; recovery is the usual termination. The prognosis therefore is favourable in these affections. Ingrowing toenail may be mistaken for this disease, but the ulceration in this disease is of short and limited duration, and does not begin first on the matrix. It may also be confounded with phytoform degeneration of the nails, but this disease

* Rayer. "Traites des Maladies de la Peau." Pathological Society's Transactions.—Hutchinson.

assumes a more dry character, and does not affect the matrix.

I propose to refer to affections of the *mucous membranes* very shortly, as I shall have to devote a little time to the more important affections of the skin in infantile syphilis, which concern us most. These secondary affections of the mucous membrane, which is really the inner skin lining of the body, is merely a reproduction of the cutaneous eruptions, observed on the skin of the surface of the body, and, like the exanthematous syphilo-derms, manifest themselves either as erythematous patches, papules, or pustules, which usually terminate in slight ulceration, and which leave behind no evident trace of their action. The vocal pharyngeal and laryngeal mucous membrane are the usual sites of this erythematous syphilide, it shows itself as patches of more or less irregular character of a bright red colour, whitish in the centre, with some swelling of the mucous membrane, which appear upon the soft palate, cheeks, inner surface of the lip, and of pharynx. The patients complain of pain and sore throat, with dryness of the throat, rendering the action of swallowing painful.

Its duration, like that of specific roseola, is generally long, and often relapses.

The intestinal mucous membrane is often affected with these erythematous or secondary deposits, as is evinced by the frequent occurrence of gastro-intestinal derangements that occur in the early stages of syphilis.

The mucous membrane of the nose, larynx, trachea, and bronchi may also be affected in the same manner, and they secrete an offensive ichorous discharge. I cannot here, however, enter on a description of each of these several affections; syphilitic laryngitis alone would take a considerable time to describe accurately.

The nostrils, tongue, anterior pillars of the palate, tonsils, and internal surfaee of the pharynx and larynx, may be the site of superfieial uleeration. Uleers of the tongue generally oeeupy the tip and edges of that member, and appear as small yellowish disseminated spots or uleers, whieh have a prieking sensation to the patient. Sometimes the disease oeeurs as painful fissures on the surfaee and sides of the tongue.

The aphthæ and stomatitis produeed by mereury, are affeetions whieh very mueh resemble these seeondary uleers of the mueous membrane, and it is important to reeognise the differenee.

The favourite site of these uleers on the larynx is that part above the glotis and the upper and lower voeal eords. Hoarseness and roughness of voiee and eough are the usual symptoms that eorrespond to these uleers.

Mucous Patches are lesions eminently eontagious, and are charaeterized by elevations of the skin or mueous membranes, the edges of whieh are distinetly eireumseribed with a surface more or less grey and moist, whieh diseharges a dirty fœtid fluid, whieh is so irritating to the neighbouring parts that it gives rise to the growth of vegetations and eondylomata. They may invade all the regions of the body, but the genito-anal is their favourite site. They may be met with on the vulva, anus, thighs, mouth, lips, inter-digital spaees, nipples, groins, and about the ears, but more espeeially those parts of the body that are warm and moist, most frequently the vulva in the female—the anus in the male. Vegetations—ealled also eauliflower exereseenees, warts, fieus, eoeks' eombs—are a kind of papillary hypertrophies, and are usually found situated upon the glans penis in males, the labia in females, the verge of the anus, and on the larynx.

Icterus may be attributed to congestion of the liver in

syphilis. The skin presents a dark jaundieed tint, variable in intensity, but not of long duration, and with favourable termination.

Of the syphilitie affeetions of the eye, we may see ophthalmia, iritis, ehoroiditis, and retinitis.

IRITIS being the eommonest affeetion, I purpose saying a few words about it. The eye is red in eonsequenee of the injeetion of the vessels, the iris is dull at first, then assumes a greyish dark eolour, with sometimes small dark elevations on its surfaee. It is aeeompanied with pain, watering of the eyes, and photophobia, and the vision is more or less impaired. The diagnostie points between rheumatie and syphilitie iritis are :—

	SYPHILITIC.	RHEUMATIC.
1.	No aeute symptom.	Always aeute symptoms.
2.	Slow development.	Rapid development.
3.	Greenish diseolouration of Iris; dimness of eornea and aqueous humor.	No diseolouration of Iris, eornea and aqueous humor retain their transpareney.
4.	Punetated keratitis, in last stage.	Never punetated keratitis.
5.	Condylomata of Iris.	No eondylomata.
6.	Very little photophobia.	Intense photophobia.
7.	No watering of eyes.	Mueh watering of eyes.
8.	General dulness of eyes.	Eyes unusually bright.

Syphilitic Iritis should always be promptly and earefully treated, if not, it may extend to the ehoroid and retina, and eause destruetion of the eye. The late form is always the most grave and most likely to permanently affect the sight.

Tertiary Affections of the Skin, or the *Period of Gummy Products.*—In all the preceding affections I have described, syphilis was limited chiefly to the skin, mucous membranes, and to some of the organs of special sense. Now the disease extends to every part of the body where connective tissue exists. It is no longer simple hypercræmias we have to deal with, but deep changes, slow in evolution and marked by chronic inflammation.

Sometimes extensive and disseminated in a single member, sometimes more limited and circumscribed, these changes appear as nodules or tubercles and it is to these we give the name of gummy tumours. The cellular tissue then, is the seat of this syphilitic neoplasm or new growth. If the neoplasm is deposited in large masses, it is of low vitality, its elements soon undergo a retrograde change, a degeneration commencing from the centre of the mass and extending to the periphery; if the growth is not so abundant it becomes formed into tissue, analagous to its surroundings, viz., cellular tissue.

These gummata may be found in all parts of the body. We may also now see—1. *Deep seated syphilides* presenting themselves in groups of crescental shape, having a coppery colour and looking brawny. 2. *Tubercular syphilides*, of which there may be two kinds: 1st. The dry tubercle. 2nd. The ulcerating tubercle—and the perforating tubercule-ulcerating tubercle—as evinced by perforating ulcer of the palate. The prognosis of all these tertiary lesions are much more serious than those hitherto described, and betray a much graver affection of the system.

Pathology.—The chief changes found in the skin in syphilis, is the formation of a new cell growth or granulated tissue. These cells vary in character very little from lupus cells. The induration tissue is formed by distension of the rete Malpighii by proliferation of its cells, which undergo fatty

degeneration. The vessels become clogged with deposit of cell growth along their course. The changes in the skin that take place are the formation of scars, by a process of atrophy.

I have already referred to the *differential diagnosis* of specific eruptions, in the individual description, sufficiently.

With regard to the modes of contagion, we are fully well acquainted—viz., by coitus, by kissing, suckling, vaccination; various occupations favour its contagion, glass blowers, etc.; various objects, *i.e.*, glasses, kitchen utensils, clothes, and it has been transmitted by other methods also.

No age is exempt from syphilis.

There is no disease so important to remember, as to its *Treatment* as syphilis. It is one thing to treat a patient, but quite another to treat the disease. No two patients can scarcely be treated quite the same.

As we dermatologists see the disease, we can but keep it in check and stay its further progress. If I referred to the various methods of treatment for syphilis, I could fill a volume. Mercury and iodide of potassium are our chief weapons, and certainly are the most reliable when used judiciously. There are various modes of administering mercury—viz., internally; and externally by inunction, by the vapour bath, by hypodermic injection. The iodide of mercury offers the best results in internal treatment. The exhibition of mercury in small doses for six months and longer sometimes, then the administration of iodide of potassium and bark, the application of mercurial ointment to the eruptions of the skin of the primary manifestation, and iodoform in the tertiary also offer good results. It is a good plan to administer iron with mercury internally.

Diet and Hygiène form two very important factors in our treatment of syphilitic eruptions. The importance of suitable, unstimulating diet, plenty of fresh air, of moderate

temperature, and a fair quantity of exercise, cannot be too strongly urged. In my experience, excess in alcoholic drinks acts as a specific poison in syphilis. Bathing too, both by the vapour bath and warm bath, materially help us in the treatment of these affections, and a healthy industrious life, as much as possible with residence in the country.

The *complications* we meet with as dermatologists are chiefly gout, rheumatism, scrofula, and lupus. There are certain diseases which are much influenced to the worse by syphilis, such as before-mentioned, gout, rheumatism, scrofula, tuberculosis. The symptoms of these diseases are always increased by syphilis, and in scrofula and lupus, if there be any, the ulcerations are more severe and intractable to treatment.

HEREDITARY SYPHILITIC ERUPTIONS OF THE SKIN IN EARLY LIFE,

OR,

Congenital Syphilo-Dermata.

CLASSIFICATION.

Class.—Congenital Syphilo-Dermata.

Variety.—Congenital Syphilitic:

I.	Roseola,	
II.	Lichen,	,,
III.	Psoriasis,	,,
IV.	Eczema,	,,
V.	Pemphigus,	,,
VI.	Impetigo,	,,
VII.	Ecthyma,	,,
VIII.	Herpes,	,,
IX.	Ulcerations,	,,
X.	Onychia.	,,

Introduction—History—Character of Eruption—Period of Accession—Classification—with their Prognosis, Diagnosis, Etiology, Treatment, Diet, and Complications, and a Contrasted Parallel of the Stages and Symptoms in Acquired and Inherited Syphilis and its Eruptions.

In this paper on the Congenital Syphilo-Dermata, or the Congenital Syphilitic Eruptions of the Skin in Early Life, I enter upon a subject on which there has been much controversy; and as I wish to devote attention, more especially to the eruptions of the skin in early life, I cannot enter into the question of the origin of the primary disease—its nature and causes—here. I therefore confine myself to the eruptions on the skin due to congenital syphilis in infant life. By this I do not imply that syphilis

produced by an actual contact with a chancre, as in the case from an affected nurse or mother to the infant at the breast,—this is acquired syphilis,—but that form of disease which affects the fœtus in utero before the development is complete.

History.—Congenital syphilitic eruptions, though slightly known by writers on the subject in early times, have only been truly investigated since the end of the last century. In 1592, Paracelsus wrote on the hereditary syphilis, but knew little of the eruptions of the skin which it produced. Several authors also wrote upon it—amongst them were Farrier, Peter Hachard, Fallopius, and Ronslet—but were little more advanced in their knowledge of the subject. In the seventeenth century the hereditary transmission of syphilis was admitted by Garnier and others, then by Levret, a great accoucheur; and in 1780 the truest accounts of the chief external manifestation of the disease, were given by Bertin, Faguer, and others, and a special hospital for pregnant women affected with syphilis, and their children, gave them ample research. In our own time we are much indebted to Trousseau, Depaul, and others, who have contributed much to our knowledge. Our general and special hospitals now afford us great opportunities of investigation and research, more especially in the skin departments, and the Skin and the Lock Hospitals. But we should always bear in mind that in juxtaposition with infants recently born, presenting all the characteristic symptoms of the disease, we are sure to see others affected with the most uncertain symptoms, in whom there are exanthematous and ulcerous lesions about which there cannot exist even a suspicion of syphilis.

Symptoms.—Inherited syphilis shows itself 1st, and most unfortunately, on the skin; 2ndly. Upon the mucous membranes; 3rdly. In the subcutaneous cellular tissue; 4thly. In

the muscles and bones; 5thly. In the internal organs or glands. But it is the eruptions of the skin we are interested in.

Hereditary syphilis may be derived before or after conception — 1st. Through the mother; 2ndly. From the father, the mother being healthy; 3rdly. From parents that are both syphilized—and it is here that we get most of the graver symptoms following. It is seen about the second or end of the third week, and seldom after the sixth month. No one can mistake the affected child, its skin presents a dirty shrivelled aspect, exfoliating and dry; it hangs in folds, and shows patches of erythema about the genitals and buttocks. In the greater number of cases of no definite size or shape, they are not raised above the surrounding level of the skin. In severe cases the patches are of a deep crimson hue, sometimes travelling along the backs of the thighs, down to the soles of the feet, and in an upper direction, above the umbilicus, of a scaly white nature on a red and inflamed base.

Coryza is one of the first symptoms: the child breathes with difficulty, causing "snuffles," a very characteristic primary sign; and if the genital organs are much attacked it screams continuously, especially when washed, or even touched there. The cry of the child is harsh and shrill, characteristic of syphilis, and the "snuffles" are caused by the inflammation, and often ulceration, of the mucous membrane of the nasal cavity. We also have mucous tubercles about the mouth, anus, fissures at the angles of the mouth, inflammation of the thymus gland, and the various eruptions, which I am about to mention, especially about the hands and feet; sub-acute onychia and high-arched palate are often seen. It is not only the very young that are attacked with congenital syphilis, but those later on in life; and many various forms of anomalous eruptions, papula, pustular, ulcerations and gummata are

plainly traceable to syphilis, though often mistaken for scrofula and struma. Of course these eruptions are much influenced by time and the hygienic circumstances, in which the patient is situated. These late eruptions hold a very important place in skin diseases; as we so often come across them, and must diagnose them by exclusion; all causes not offering sufficient evidence are put aside, and the usual cachectic condition must be sought for—the remnants of old mischief—such as indentation of the teeth, keratitis, mucous scars, and more especially the characteristic nature of the eruptions.

As the disease improves, we may notice a gradual fading of the deep-red colour; it assumes a mottled character, small rose-red spots are seen, surrounded by healthy skin.

Again, the disease does not always make its appearance upon the genitals; it is often noticed, first upon the palms of the hands and soles of the feet, and is recognized by the split and shred epidermis over it, and by its deeper colour. In these cases the nails are often affected, the edge becoming very irregular, the surface uneven, and the nail loses its attachment to the matrix, ulcerates and falls out, and it is often a considerable time—some months—before these structures recover themselves in a healthy state.

Character of Eruption.—Congenital syphilo-dermata exhibit very much similar manifestations in the skin to ordinary eruptions, but they also contain special characteristics, viz.:

1. The usually symmetrical character of the eruption and its circular or horseshoe shape.

2. The hereditary history of syphilis.

3. The brownish-red colour of the stains left by the eruption, and the coppery hue of the eruption itself.

4. In the scaly eruptions the scales are small, pearl-like, glistening, circular, and fewer in number than non-specific eruptions.

5. The ulceration and cicatrization of specific eruption is always recognized by its punched-out edges and its ashy-grey colour. The cicatrix is white or dull brown, leaving stains, and the crusts are firmly adherent and of greenish colour.

6. The polymorphous character of the eruptions, many varieties, existing at the same time.

7. These eruptions are usually unattended by pain or irritation, except in early life, when mucous tubercles are seen upon the infant, and are in process of ulceration.

Period of Accession.—No date can be very accurately assigned to the accession of a specific eruption, for however severe the symptoms and the eruptions may prove, the child, as a rule, is born in perfect health, with a sound, clear skin. It is seldom seen at birth, or even in the first week or ten days, although a certain number of fœtuses die in utero, for the only reason that they are already affected with the disease. I have seen several instances of this kind at still-birth. At other times they are born with unmistakable signs of syphilis, as noticed by Sir Astley Cooper and others. Out of a number of cases that I have seen, in which I have been careful to look for the slightest early sign, in only three have I seen eruptions in the first twelve days showing themselves. It is at the second or third week that the disease generally shows itself, and up to the fourth week. The average is much the same, but beyond this time, and at two months, the symptoms are always less.

Therefore, the inference we may draw from this is that if the surgeon has no certain information of the source of the disease, he will be able, by calculation of probabilities to come to a pretty sure conclusion that the disease is either hereditary or acquired, as it manifests itself, either before or after the third month of life. Such is the rule;

but it must not be supposed that eongenital syphilis never shows itself after that period. For the disease is frequently very tardy, and we are led to infer that it must be the consequenee of the parents being long affeeted with the tertiary manifestations of the disease. Palmar psoriasis is a eommon oecurrenee in the parents, one or the other side, when this is the case.

The eutaneous manifestations of congenital syphilis do not differ very materially from those of acquired syphilis. Papules, vesieles, pustules, and erythema, are the most frequent anatomieal lesions observed; tubereles being of somewhat rare oeeurrence, and bullæ frequent.

Roseola.—The first eruption we eommenee with in their order is Roseola syphilitiea; this is one of the earliest signs of eonstitutional syphilis in the infant. Bassereau* saw it in several instanees break out on the third day after birth. I have seen a few sueh cases of it; it has the appearanee of a papular erythema, liable to spread over the whole trunk, eommeneing on the genitals and buttocks, or the forehead and faee, of a distinct eoppery hue. Sometimes it shows itself as small spots, the size of lentil seeds, and appearing simultaneously as yellowish-red spots without induration or alteration of the epidermie struetures. In eourse of time these spots beeome elevated, the colour deepens, they flatten and become eovered with very fine scales.

If the little patient is treated with suitable remedies, the eruption will very soon fade; if not, the spots become infiltrated, the crusts exude a serum, and are eovered with yellowish seabs; and if it appears on the nates, if the discharges are allowed to remain, excoriations will form, and nasty eethymatous ulcers take plaee. The palms of the hands

* "Traité des Affections de la Peau Symptomatiques de la Syphilis," 1852, p. 541.—Bassereau.

and soles of the feet often show this ecthymatous eruption, and it is an important diagnostic of congenital syphilis.

Lichen.—The second variety, or the papulous form, is seldom seen by itself, but co-exists with roseola or pemphigus syphilitica; the papules are of a brownish colour, hard without areola, and are seen upon the inner surface of the extremities, the palms of the hands, and the soles of the feet. The eruption is not successive, for it comes to maturity in a few days; but it may show itself in several different fresh outcomings of the disease. This variety usually lasts about a month, leaving behind small pits, which are most characteristic. It commences with follicular hyperæmia, and is accompanied with erythema, subsiding into the coppery-coloured stains. The diagnosis of specific lichen is generally easy. The specific history, the absence of itching so well-marked in the non-syphilitic variety, and the concomitant signs of mucous tubercles, roseola, are conclusive.

Psoriasis.—The next, or third variety, the squamous syphilide. Psoriasis commences generally on the face or upper extremities. The face is seen to be covered with thick white scales or crusts, perfectly dry, and unaccompanied by erythema. The eruption is usually symmetrical and circular in form. If the eruption is severe, the skin round the mouth becomes fissured and easily breaks; the irritation is greater, and the child endeavours to tear the skin. In others the symptoms are less evident, the surface of the skin being only rough and slightly marked with fissures. As these evidences of the disease decline, they, too, leave the brownish stains behind, and long after the child becomes to all appearances healthy, faint cicatricial lines are left behind, the only remnant of the disease. There are several important signs of diagnosis of the squamous syphilide that should be noticed, viz.:—

1. The serpiginous eharaeter of the eruption.

2. The disease seldom attaeks the anterior aspeet of the knees and elbow-joints, as is invariably seen in the non-speeifie variety.

3. The squamæ are small, of pearly whiteness, isolated, and surrounded by a eoppery areola.

4. The speeifie history of the eruption.

5. The eoppery eoloured maeulæ left behind.

Eczema.—I find, from the statisties of a number of eases I have seen, that syphilitie eezema is the least eommon variety of this elass of eruptions. It sometimes oeeurs immediately after birth, but more often at the age of a month. In a short time there beeomes seereted from a very vivid pateh of erythema, a clear eolourless fluid, similar in many respeets to ordinary eezema. These eezematous patches are usually the forerunner of eezema of the genitals, so very troublesome a form of eruption; and there nearly always eo-exist other loeal signs of eonstitutional misehief. When this eruption appears on the sealp, it is unlike the ordinary eezema eapitis, by reason of the abundant eharaeter of its diseharge, its elevated erusts, often tinged with blood, and its numerous isolated pustules surrounded by the usual red areola.

Pemphigus.—The variety pemphigus serves to eharaeterise a eutaneous lesion, showing bullæ, varying in size from a split pea to a walnut. In eertain eases the disease differs mueh from others, and eomes in with vesieles, bullæ, and large blisters filled with a viseid elear serum of a brownish or yellowish eolour surrounded by a narrow red areola. The eontents of the bullæ are sometimes thiek and purulent; they are isolated in form, eoaleseing oeeasionally only, and are most often seen on the soles of the feet and palms of the hands. The bulla eollapses after a

few days, and a very fine cutieular sac is seen; or the crusts dry up and a red base is shown after the epidermis is exfoliated. The lesion is much like that produced by a blister or burn, and shows how the skin evinees its aptitude to vesieular inflammation when irritated by internal or external agents, through the vaso-motor system—a eommon cutaneous law. The plaees most likely to be affected are the palms of the hands and the soles of the feet, the genitals and thighs, or even the whole body. It is not possible for deep ulcerations to form in this syphilitie variety, for the sole reason that the infants rarely live long enough—for they usually perish with this eruption from weakness and exhaustion from the poison.

The prognosis in this variety is almost invariably fatal, and children who are born with it die in a few hours or days; but if the disease shows itself a week or so after birth, the child may live for a few weeks—though scarcely one in a thousand will live even if this is the case, for there are sure to be some internal severe lesions of viscera and extreme eachexia.

The diagnosis of pemphigus is generally easy, provided we take into consideration the seat of the affection and the epoch of the eruption; the site of the eruption, on the palms of the hands and soles of the feet, and the genitals, being the diagnostie point. Other varieties occupy indiscriminately any part of the body.

Impetigo.—Speeific impetigo is usually seen upon the face, but the neck, ears, and groins are not exempt from its attack. The eruption is seen to consist of numerous confluent pustules, which burst and pour out a thick yellow pus, which rapidly forms into crusts. The base of these crusts is surrounded by a red areola, and small ashy-grey ulcers are seen here and there on its surface. These latter signs are the main points of the diagnosis from ordinary

impetigo, which is generally observed on the scalp and about the mouth of children.

Ecthyma.—Syphilitic ecthyma in the new-born child is usually seen about the trunk and lower limbs, and is a very serious and indolent eruption ; it occurs as mottled patches, which become converted into hæmorrhagic pustules with a very coppery base, and which become covered with dirty brown scabs, sometimes concealing a deep ulcer, with clear cut edges, capable of making great ravages into the skin in a few days. The crusts in this variety are very thin and adherent, and they leave the usual staining of the skin when they fall off. The analogy of herpes, pemphigus, impetigo, ecthyma, and rupia are very close indeed, and I am inclined to look upon these several congenital specific eruptions, as in the non-specific varieties, as only a severe degree of comparison of the primary vesicular eruption or lesion, and to a great extent influenced by nerve irritation and perversion.

Herpes.—Specific herpes is a rare eruption, but it is occasionally seen on the face in the second month of infancy, and on children whose parents have a distinct tertiary syphilitic history. They are more indolent in nature than the ordinary form of eruption, and their edge is well defined and has the dark-red areola. The crusts that form are large and adherent, and the eruption is generally annular in form.

Ulcerations.—Another attendant of congenital syphilis are ulcers, or rhagades, and are seen on the mucous surfaces of the mucous membrane of the lips and mouth. They occupy the commissures of the lips, the angular and central, and spread superficially, forming crusts which cause the lips to be very brittle, and consequently when stretched are very painful to the child, as they crack, break, and bleed. If it occurs to the lower lip eversion

may take place, and, as a result, an ulcer forms on the tip of the tongue where it touches it. These fissures may also be met with at the nares, anus, and vulva in girls, and occasionally at the angles of the eye; on the scrotum they may be seen very numerous about the size of a pea, they issue a slight discharge, and accompanied by the usual redness, soon fade. This variety is important, for it is by this means that the healthy nurse may become affected by the ulcerated mouth of the child.

Onychia.—Specific onychia may attack the nail and its matrix also; and in the early period of life attacks often several nails at the same time; sometimes it shows itself as isolated pustules on the finger-ends, and in whatever form it comes, it is sure to cause the nail to fall off. The local symptoms are pain, heat, redness, and swelling of the matrix.

Prognosis.—Now with regard to the prognosis of congenital syphilis and its eruptions. Infants, from the first, are affected with a cachexia, from which in later life adults do not always escape. In proportion to the greater or less severity of the symptoms, so will there be the greater or smaller chances of life. It might be thought that an outbreak occurring a few days after birth would be more likely to recover than that which shows itself in a month or so; but such is not necessarily the case, nor is the child affected materially by the infection of either the mother or father, as might be thought. Loss of flesh and emaciation are the most unfavourable symptoms, especially when progressive. When asked to see a syphilitic child, we ought to be most careful how we prognose; watch the most trivial affections, the slightest functional derangements, and not look to the eruption of the skin as the most important aid in arriving at a conclusion as to the state of health of the little patient. When the skin has a dirty-

white hue, hangs soft and flabby, is cold and dry and loses its elasticity, the face shows signs of distress, the brows are knitted, the child constantly cries, and presents a pallor of œdematous nature, an inordinate craving for food, severe eruptious of the skin, as pemphigus and others, then the prognosis is grave. But should the infant be no longer affected by sores, sleep better, lose its pallor, the skin affections become slight, and the face assume a cheerful expression, these changes taking place during the early months or period of treatment, then a favourable result may be confidently expected and prognosed.

Etiology.—The development of secondary in contra-distinction to tertiary syphilis—as, for instance, psoriasis palmaris—observed in either parent before marriage, and from which they have scarcely recovered, is one of the most frequent precursors of infantile syphilis. I have seen many examples of this kind in its history. The same may occur with eczema in the parent. The mother may remain uncontaminated, and nevertheless bring forth a syphilitic child. If the mother is infected with secondary syphilis, the fœtus in utero will hardly ever come to maturity, but will abort. Therefore, in the great majority of instances the disease descends from the father, but this is not absolutely the rule. Tertiary syphilis, I believe, seldom leads to congenital syphilis—at least not in early life. There is one more important fact: that the child who inherits the disease entirely from the father will not inoculate its mother in nursing, but will inoculate a healthy wet nurse, if she has the slightest sore or crack, and the child has mucous ulcers in its mouth; and finally, fathers infected with secondary syphilis will not always beget syphilitic children.

Diagnosis.—We must not always infer when we see a red patch of eruption about the genitals of children, that

it is neeessarily speeific. For often we may observe in children, especially fat ones, a kind of erythema, assuming a very red tint, from the folds of the skin being brought into very elose eontaet, or the use of impure powder or fuller's earth, or want of eare in removing the alvine seeretions. Eezema may oecur on the genitals of infants, as upon other parts, but it has not the coppery hue of the specifie form, and ordinary eezema is more scattered over the body. In eongenital syphilis and its eruptions we must rely solely on the symptoms as they show themselves, without regard to any other testimony. Any history which might tend to eompromise the parents is best withheld, or for various reasons, is not sought. The rapidity with which these eases yield to speeifie treatment is a very powerful aid to our diagnosis.

Course.—Even after treatment, the disease is liable to relapse, the same symptoms being repeated, or a liehenous eruption appears on the face, as small red papules like millet seeds; or the disease may run a downward course, and if the infant is brought up by hand it will suecumb early to anæmia, those that are nursed by the mother having the best chances of living.

Treatment.—In the treatment of eongenital syphilitic eruptions, the internal cautious administration of mereury and iodide of potassium in very small doses must undoubtedly prove of the greatest serviee to us. The direet method, also, is the only safest eourse: some authorities advise that the mother should be put under treatment rather than the nurseling infant; but unless the mother is also infeeted this treatment is unadvisable. Now, as regards the form of mercury that is best to administer, the perehloride is preferable, its strength being known, and its capability of being preseribed with other drugs, as iron, adds to its efficacy. Grey powder is one of the worst pre-

parations that we can use, for we can put no reliance upon it at all, so variable is it in preparation and so acted upon by climate. In a child of four weeks old or under, three or four minims of the liquor hydrarg. perchlor. will be sufficient, and with compound tincture of camphor and syrup of iodide of iron makes a nice mixture. I do not like giving any of the stronger preparations of opium to infants, no matter how pure they are, to allay the griping effect of the mercury. Another good method of treatment is the nightly inunction of about five grains of the unguentum hydrarg. fort. into the soles of the feet or on to the abdomen, the child wearing socks to keep the ointment from rubbing off, or a flannel binder. As local applications to the eruptions, use either calomel, the red oxide of mercury, or the ammonio-chloride of mercury, of very weak strength, with vaseline or benzoated lard. The latter is the best vehicle for all the mercurial preparations. The greatest cleanliness of course is essential. The alvine secretions should be most carefully removed, as soon as they are evacuated, and the parts dusted with a little powdered starch. If the infant suffers from snuffles, the best treatment is to inject a little warm water into the nostrils with a very weak solution of black wash or carbolic acid. The duration of the treatment much depends on the complications, condylomata, and the requirements of each case; but it should not be discontinued under one month at least, until all signs of eruption or erythema have passed away, otherwise we may have to deal with relapses, which are sometimes very troublesome.

Hygiène and Diet.—The surroundings and diet are very important elements in the treatment of these congenital syphilitic eruptions, and fresh air, above all things, should the child be suckling. The mother's milk, if healthy, is undoubtedly the best food and the most natural up to the age of five or six months; then a diet of baked flour,

biscuit food, or good cow's milk, with one-third milk and two-thirds water sweetened with milk sugar. With artificially fed children, the chief thing to avoid is diarrhœa, which can be done by great care being taken in the preparations of the food and mode of giving it. If this is succeeded in, the infant will almost always surmount the disease. With regard to fresh air, the wealthier classes of course can cope with the evil of keeping children affected with syphilis in the close unhealthy atmosphere of large towns; but by far the greater number of people cannot do so, and the disease is too often aggravated by the unhealthy air in which they dwell, besides defective nutrition; we cannot therefore be surprised that great numbers of children are added to the list of our mortalities.

The complications of congenital syphilo-dermata are very numerous—for instance, coryza, pharyngitis, laryngitis, lesions of bone and periosteum, lesions of the mucous membrane of the alimentary canal and peritoneum, lesions of the liver and thymus gland, lymphatic glands, supra-renal capsules, and changes in the blood, pneumonia, and hydrocephalus,* insomnia, convulsions, vomiting, diarrhœa, and condylomata. The late development of inherited syphilis and its eruptions, holds also a very important part in the clinique of dermatology.

Pathology.—The chief changes found in the skin in the syphilo-dermata is the excessive hyperæmia of the cutis, the formation of a new cell-growth similar in character to granulation tissue and that of lupus. The indurations, if examined microscopically, will show the rete Malpighii greatly swollen by proliferation of small cells which undergo fatty degeneration in the papules and tubercles; this is seen to be well-marked in the case of condylomata, which are nothing more than enlarged tubercles. If the disease

* De Meric.

is severe the connective tissue is greatly distended by this new cell-growth. When the disease has undergone absorption, the cornea becomes atrophied, and the follicles, hair follicles, glands, and papillæ become destroyed; and in proportion as the degree of mal-nutrition takes place, so will the deposit soften and break up to ulceration.

A CONTRASTED PARALLEL OF THE STAGES AND ACQUIRED DISEASE.

Stage.	Symptoms.	Duration.	Remarks.
PRIMARY. Local or stage of inoculation.	An ulcer (chancre) usually with indurated base Indurated lymphatic glands from breast of nurse.	The sore, appears after an iucubation period of from ten to twenty-eight days, and if not treated may remain from a fortnight to six months. Liable to relapse.	Induration is to be regarded as the earliest proof of successful inoculation, but the latter is sometimes affected without any hardness of the original sore having shown itself.
SECONDARY Constitutional or exanthematic.	Febrile disturbance, malaise and muscular pains. Slight engorgement of lymphatic glands in many parts. A symmetrical, and usually copious, eruption on the skin, and often on exposed mucous surfaces. Symmetrical ulcers in tonsils.	Usually commence within six weeks or two months of the inoculation, and if not treated may last from three to six months or to a year. Essentially transitory, and will disappear without treatment.	This stage may be either exceedingly slight or very severe. Its severity appears to bear proportion to the degree of induration of the preceding chancre. It is often noticed that the rash comes out in successive crops. The rash may also vary very widely as to its character, —roscolous, scaly, papular, pustular, ecthymatous, &c., being modified probably by peculiarity, first, in the course of contagion; secondly, in the state of health of the recipient.
INTERMEDIATE. Stage of latency and of relapses.	The patient may be either wholly free from symptoms and in good health, or may remain pale and rather feeble, and liable from time to time to slight returns of eruption on the skin, sores on the mucous membranes, condylomata.	This stage may be said to commence at from a year to a year and a-half after the contagion, and to extend over a period which may vary from three to five, ten, or even twenty years.	The relapses during this stage are usually easy to be distinguished from true secondary symptoms. There is little or no febrile disturbance, the rash is not copious, and often not symmetrical.
TERTIARY, or stage of sequelæ.	All the symptoms in this stage occur, as a rule, without symmetry; sometimes multiple, but not unfrequently single. They consist of chronic inflammations of deep tissues, or of the deeper layers of superficial ones, *e.g.*:—	This stage commences at from four to ten or to twenty years after the contagion, and extends indefinitely very often to the end of life.	All the inflammations in this stage are remarkably under the influence of treatment by iodide of potassium, but tend to relapse. Unless so treated, all of them tend to progression and permanent disorganization of the part attacked, none of them to spontaneous recovery.
	Inflammations of periosteum and bone resulting in nodes; of cellular tissue, tendon, or muscle, resulting in gummy tumours; ulcerative destruction of the palate and pharynx; serpiginous ulcerations of the skin; inflammations of nerves, or even of cerebro-spinal centres, inducing various forms of paralysis; deposits in liver, lungs, &c. Probably but little liability to transmit the disease to offspring.		

SYMPTOMS IN ACQUIRED AND INHERITED SYPHILIS.

INHERITED DISEASE.

Stage.	Symptoms.	Duration.	Remarks.
PRIMARY.	This stage has been passed through by one or both of the sufferer's parents within from a few months to twenty years of the infant's birth. The infant is usually free from all symptoms at the time of birth.	The infant usually remains without symptoms for from one week to three months.	
SECONDARY. Constitutional or exanthematic.	Inflammation of nasal mucous membrane causing "snuffles." A symmetrical and usually copious eruption on the skin. Wasting; fretfulness; a peculiar odour; a withered, senile aspect; inflammation of the mouth, and condylomata at anus.	From the age of two to four weeks to the end of the first year. This stage is essentially transitory, and will disappear without treatment, if the child lives through it.	The eruptions which occur differ from those of acquired disease, chiefly in being more moist, and in preferring the thighs and genitals. These differences may, in part, be due to peculiarities in the skin of young infants, and to the constant irritation from urine to which the nates are liable. Dry scaly rashes are rare. In infants this stage often proves fatal.
INTERMEDIATE. Stage of lateney.	The patient will probably be wholly free from active symptoms, but will show various indications of his diathesis in pallor of skin, sunken nose, protuberant forehead and premature loss of the upper incisor teeth. Sometimes there will be a remarkable retardation of growth and general development. If second dentition have occurred, the central upper incisors will be malformed.	This stage extends from the end of the first year or eighteen months to the second dentition the time of puberty, or even very much later.	Unlike what happens during this stage in acquired syphilis we scarcely ever observe any tendency to recurrence of the secondary symptoms. Now and then we see condylomata at the anus returning during the first five years, but the rash of infantile syphilis having once disappeared, I think, scarcely ever relapses. A certain degree of nasal obstruction sometimes persists, but not often.
TERTIARY, or stage of sequelæ.	Most of its symptoms are symmetrical:— Phagedænic or serpiginous ulcerations of skin; cellular nodes (rare). Probably not liable to transmit the disease to offspring.	This stage may commence with the second dentition, at the time of puberty, or not till much later. Its duration is quite indefinite.	The symmetry of the symptoms is in marked contrast with what occurs in this stage of acquired disease. The paralyses of single cranial or spinal nerves so common from acquired syphilis are, I believe, never met with in the inherited form. Most of the inflammations tend, unless arrested by treatment, to permanent disorganization, but one (interstitial keratitis) tends to recovery even without treatment. They are much less easily influenced by treatment than those of the acquired disease.

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